



DS0318

EMPLOYMENT AND BENEFITS INFORMATION
DS0318 (REV. 01/00)

Member's SSN: - -		Member's Name: (Last) (First) (M/I)	
ONE YEAR FINAL COMPENSATION			
<input type="checkbox"/> I certify pursuant to the district bargaining agreement, the present value payment for one year final compensation will be made to CalSTRS within 30 days of billing for the above captioned member.			
MEMBER'S EMPLOYMENT DATA			
Dates of employment with this district: (Mo./Day/Yr.) From: Thru:		Current Status: <input type="checkbox"/> Paid sick leave <input type="checkbox"/> Unpaid leave <input type="checkbox"/> Resigned <input type="checkbox"/> Differential pay <input type="checkbox"/> Still working <input type="checkbox"/> Terminated	
I certify that this member's salary was reduced because of a reduction in school funds. This entitles him/her to use any three non-consecutive years for final compensation. School Years Reduced:			
If either of these dates below change, please send a corrected copy of this form to CalSTRS immediately.			
Last day of actual performance on the job: (Mo./Day/Yr.)		Last day of compensation for service performed, differential and/or sick pay: (Mo./Day/Yr.)	
Days of absence in the current school year:		Days of absence in the prior school year:	
Type of contract: <input type="checkbox"/> Full-time <input type="checkbox"/> Less than full-time —————▶		If less than full-time, please indicate type of position: <input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Annual Contract <input type="checkbox"/> Percentage of Contract	
Did member work less than full-time due to illness? <input type="checkbox"/> No <input type="checkbox"/> Yes —————▶		If Yes, when did member begin working less than full-time? (Mo./Day/Yr.)	
Are dismissal proceedings contemplated or pending? <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, please explain: 			

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INCOME PROTECTION PLAN			
Is a monthly benefit payable from any income protection plan such as indemnity or annuity? <input type="checkbox"/> No <input type="checkbox"/> Yes —————→		If Yes, were the premiums paid for by the school district? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If the premiums were paid by the school district, please complete the section below:			
Company Name: _____ Address: _____ <div style="text-align: center;">(Street Number or Post Office Box)</div> <div style="display: flex; justify-content: space-between;"> (City) (State) (Zip Code) </div> Telephone Number: () _____			
Remarks:			
WORKERS' COMPENSATION			
Has member applied for benefits through Workers' Compensation? <input type="checkbox"/> No <input type="checkbox"/> Yes —————→		If Yes, the benefits are paid directly to: <input type="checkbox"/> Member <input type="checkbox"/> School District	
Weekly rate of benefits? (\$)		Effective date of benefits? (Mo./Day/Yr.)	
Date of injury? (Mo./Day/Yr.)		Were benefits awarded as lump sum? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Address of carrier or company handling the claim			
Company Name: _____ Address: _____ <div style="text-align: center;">(Street Number or Post Office Box)</div> <div style="display: flex; justify-content: space-between;"> (City) (State) (Zip Code) </div> Telephone Number: () _____			
Remarks:			
CERTIFICATION			
I certify that the foregoing information is true and correct to the best of my knowledge and is in accordance with the California Education Code.			
Authorized Signature:			Date: (Mo./Day/Yr.)
Type Name:	Title:	Telephone Number: ()	